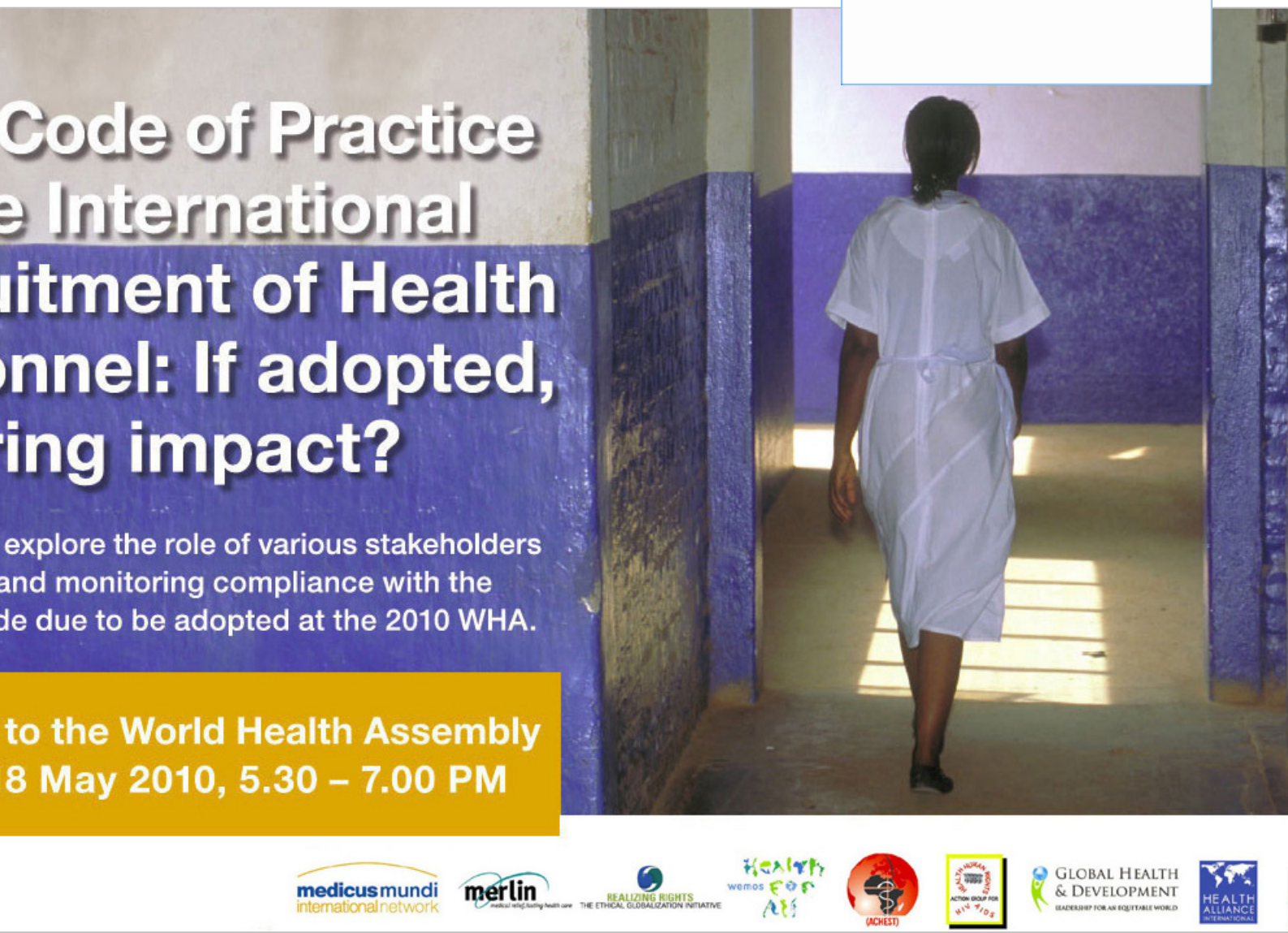


ANNUAL REPORT 2010

# *"We will make the MMI Network a real community of change for strengthening health systems"*

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**Medicus Mundi International Network: Annual Report 2010**

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# TAKING OVER THE CHAIR

BY NICK LORENZ

**One the most marking events in my year 2010 was certainly the taking over of the chair of the MMI Board in the Château de Bossey, close to Geneva, in May 2010. This is at the same time a huge honour and a challenge of not small magnitude. The challenging task is facilitated by the many years of committed work of my predecessor Guus Eskens, who has laid the ground for a bright future of the Medicus Mundi International Network. MMI owes him a lot.**

Under Guus Esken's leadership the Network policy (adopted in 2009) and a new Network strategy 2011–2015 (adopted in 2010) have been elaborated in a highly participative process. It was a pleasure for me to have the Network strategy adopted in my almost first official act as chair. Soon after we started with the implementation, with the key content element of the strategy that is the strengthening of health systems. A well attended meeting in Amsterdam allowed to create a common basis of understanding of what health systems strengthening means and entails. It provided also one more opportunity for exchange with an academic institution, as the Prince Leopold Institute from Antwerp provided valuable input.

In 2010, the Network's Human Resources for Health working group has gained momentum. The group is a good example for a living community where Network members and partners come together to share and develop their knowledge, solve common problems and develop joint activities. These have resulted in well received international advocacy in the area of human resources migration. There is certainly potential for MMI Network members engaging the same way in other emerging areas such as non-communicable diseases, mother and child health, and last but not least health systems strengthening.

The development of new partnerships between NGOs and research institutions has started to take off as well. A meeting in Antwerp brought stakeholders from the two constituencies together for a fruitful exchange.

In May last year the MMI Network could welcome two new members. Smile Train Italy and Wemos (Netherlands) are good examples for the present MMI membership as they show the wide spectrum of member organizations, as the one is engaged in very concrete service delivery activities while the latter is a well known advocacy organization. Both enrich the Network.

The future of MMI's membership is perhaps more reflected by the Africa Christian Health Associations Platform (ACHAP) and Ecumenical Pharmaceutical Network (EPN), which were admitted by the General Assembly in November. Although they seem to be at first sight typical representatives of faith based organizations, they stand for open networks. Together with Because Health, the Belgian platform for international health which shows interest in MMI Network membership, we might be slowly moving into the direction of a network of networks.

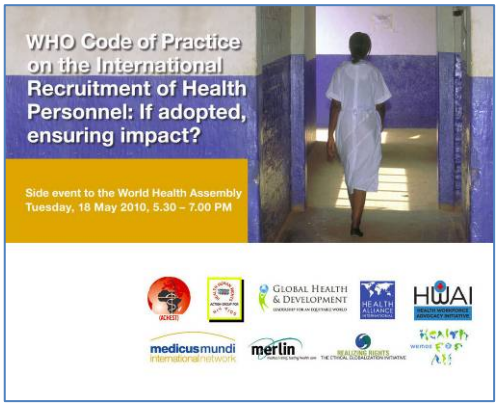
A major achievement of 2010 was also the extension of the secretariat agreement with Medicus Mundi Switzerland. It was based on a thorough review of MMS and MMI. On the basis of some contractual safeguards we are looking forward to a continued positive collaboration.

"We will make the MMI Network a real community of change for strengthening health systems." This is the optimistic slogan of the Network strategy 2011–15. The challenge for 2011 will be to maintain the dynamics and continue with translating of the Network strategy into tangible Network action and development: With the help of all of you we will be able to overcome this challenge.

Nick Lorenz, MMI President

# A YEAR WITH A HIGHLIGHT

**The Human Resources for Health working group of the MMI Network exists since 2008. Initially having had rather broad visions and plans, the group last year successfully focused its work on advocacy in the field of international migration and recruitment of health personnel and the related WHO Code of Practice. This process was strongly initiated and lead by the new Network member Wemos.**




It was in June 2009 when the MMI Secretary sent an "urgent message" to the Network members to get involved in the debate around the draft WHO code of practice on the international recruitment of health personnel: "This could be a thrilling test for future joint advocacy activities, but it needs a rapid reaction and, related to this, capacities and coordination/leadership. What can you offer?"

In fact, Network members could offer a lot. Less than one year later, the HRH working group looked back to a successful advovacy campaign – and to a historical moment: The *WHO code of practice on the international recruitment of health personnel* was adopted by the World Health Assembly in May 2010 – as only the second code of conduct ever adopted by all member states of the World Health Assembly. The code of practice sets forth ten articles advising both source and destination countries on how to regulate the recruitment of health personnel in a way that mitigates damage to low-income countries struggling to meet the basic health needs of their populations in a setting of serious workforce deficits.

As a member of a broad coalition of civil society organizations and WHO member states, the Medicus Mundi International Network participated in advocacy for the adoption of the code – and of a strong one – before and during the World Health Assembly. MMI proposed and coordinated a WHA side event that, with the former UN High Commissioner for Human Rights Mary Robinson and the former director of the Global Health Workforce Alliance Francis Omaswa as co-chairs, became a "spirited pep rally for the code" (HWAI media release).

The Medicus Mundi International Network, having itself become a member of the Health Workforce Advocacy Initiative (HWAI) and the Global Health Workforce Alliance (GHWA) earlier last year, congratulated the WHO members on having adopted the code: "We are proud of having been part of the civil society alliance advocating for the adoption of the code – and we will part of the team involved in monitoring and implementing the code."

***"MMI will contribute to the implementation of the WHO code of practice on the international recruitment of health personnel."***
MMI Network program 2011-15

In a working group meeting after the Assembly, the Network members represented in the HRH working group confirmed their interest to play a leading role in the creation of a civil society platform for collecting and integrating evidence and experiences on the implementation and monitoring of the code of practice, mainly in Europe where most Network members are based. Nevertheless, the group stated that it would remain a "human resources for health" working group, not narrowing its focus to the migration and recruitment issue only.

The HRH working group also agreed that there was still a lot to learn about the migration issue and that it therefore would make sense to begin with something concrete: Following a proposal of Wemos and Cordaid, the working group members started to drafted simple national "power maps" of actors in the field of human resources management, regulation, migration and recruitment, with the intention to use them to build national coalitions and to encourage governments to take a leading role in Code implementation, involving civil society. With their remarkable report "Chances for Change – Dutch measures to improve the global distribution of health personnel" published in the end of the year, Wemos was in the driver seat again, providing not only a benchmark, but most of all an inspiring model case to be easily used and adapted by others.


**Members of the MMI HRH working group:** Anke Tijtsma and Remco van de Pas, Wemos (working group coordinators); Martin Leschhorn, Medicus Mundi Switzerland; Agnieszka Lipinska, Medicus Mundi Poland; Carlos Mediano, Medicus Mundi Spain; Giovanni Putoto, CUAMM; Christina de Vries, José Utrera and Johan van Rixtel, Cordaid; Nina Urwantzoff, Misereor; Thomas Schwarz, MMI executive secretary

**MMI topic page:** www.medicusmundi.org/en/topics/human-resources

# ANTWERP WAS WORTH A TRIP…

**How to generate, access, share and use reliable evidence is a crucial issue for the MMI network and its members. To obtain such evidence the collaboration with research institutions both in the South and the North is vital for NGOs. Also research institutions are increasingly under pressure to produce evidence which can be translated into action. To stimulate good research questions and to provide access to research sites, the collaboration with NGOs becomes increasingly important.**

To build up mutually beneficial partnerships the MMI Network organized in collaboration with the Institute for Tropical Medicine a side event to the colloquium "Health Research towards Universal coverage" in Antwerp in November 2010. The meeting was well attended and there was a good selection of MMI members and other NGO representatives and the Belgian Be-Cause Health network.


MMI members presented case studies. MSF – by many considered as the benchmark for NGO operational research – explained its approach and some practical examples. MSF has opted for an "in-house" solution, and the results are as such impressive. However, questions were raised to what extend bias can be avoided and good science can be produced. Furthermore it requires substantial investments in human resources at central level, and has to cope with a rapid staff turnover in the field.

There was consensus that research in the NGO context is necessary, not only because of the need to work on an evidence basis, but also as way to share and to document experience and knowledge which would otherwise be lost. However, also difficulties were mentioned, such as different institutional or organizational cultures. The agenda of a research institution and an NGO are different, and attention to the modalities of the cooperation need to be well thought of, in order to make sure that it becomes a mutually beneficial collaboration, without one partner dominating the other. The respective expectations of the NOG and of the research institution need to be made explicit, discussed and acknowledged in an open way. There are numerous examples of fruitful collaborations between NGO and research institutes. However, a limitation

is for both NGOs and research institution their limited capacity (manpower, time and funding, but also institutional competencies and know-how) for this task. Preparation time can be an issue, particularly if the process is participatory.

Last but not least funding is an issue. While some NGOs have been obliged by their funding bodies to spend substantial amounts of their resources into the wide complex of research, which consists albeit mostly of evaluation and review, other NGOs have very limited amounts to available to invest into research. Some NGOs have already established partnerships with research institutions. Joint applications for funding of research (for example CUAMM and ITM) are still exceptional. For obvious reasons one has to adjust to the priorities of funding bodies like the European Union.

### After the Antwerp Workshop: Conclusions and plans

As outlined in the MMI Research Policy and confirmed in our Network Strategy 2011–15, facilitating the interaction between NGOs and research institutions will be an important task for the MMI Network in the coming years. The workshop confirmed the need to get a better understanding of the structure of collaboration between NGOs and Research Institutions, as the delineation between research and evaluation and reviews is not very clear.

***"MMI will foster mutually beneficial partnerships between NGOs and research institutions."***
MMI Network program 2011-15

Based on this first experience, are there new insights how the MMI Network can concretely contribute to the development of mutually beneficial partnerships between NGOs and research institutions? Eventually, a sort of "typology" of research collaborations between NGOs and academia could be established, based on accumulated experience and with an analysis of the pros and cons of the different types of collaboration seen from the perspective of each of the stakeholders involved. Hence the relevance for MMI to build a sort of "data-base" where different experiences and cases of collaborative research between NGOs and academic institutions is stored. Our plans also include a publication in the WHO bulletin, which will outline the MMI approach to research and NGO work. This still has to be further discussed within our group and with interested Network members and partners – who might be interested to join our team and transform it into a "proper" MMI working group.

**Members of the MMI advisory group:** Bart Criel, ITM Antwerp; Giovanni Putoto, DWA Cuamm; Nick Lorenz, MM Switzerland/Swiss TPH

**MMI topic page:** www.medicusmundi.org/en/topics/human-resources

# GETTING INVOLVED...

**Global health policy and governance are key issues for the Medicus Mundi International Network. In our recently adopted policy and strategy documents, we state that the Network intends to contribute to the dialogue on global health policy and governance, joining forces with other civil society organizations and networks.**

In his article "A stronger voice of civil society at the World Health Assembly?" published after the 2010 World Health Assembly on the MMI ePlatform and distributed by e-mail, the MMI Secretary Thomas Schwarz expressed his concern about the way civil society was virtually excluded from the World Health Assembly – and about the lack of coordination within the NGO lobby at the World Health Assembly:

*"Many civil society organizations interested in 'making WHO work better' were frustrated by the way the World Health Organization limited the role and impact of civil society at this year's World Health Assembly. But we could have done better ourselves. We will have to invest in making joint civil society advocacy at the WHO work better. And this is a real challenge, due to the civil society organizations' and networks' limited capacities, inconsistent advocacy agendas, divergent strategic choices regarding cooperation and coordination. We should not wait until the next WHA to renew the dialogue with the WHO about better access of civil society organizations to the World Health Organization and the World Health Assembly."*

When, after the World Health Assembly, the People's Health Movement (PHM) and some allied organizations and networks launched their "Global Health Governance Project", a small MMI Global Health Governance team was set up, with the intention to follow this process closely. When the PHM project became more concrete, with an initial focus on "WHO watching", José Utrera and Thomas Schwarz joined its steering group, together with representatives of other NGOs and networks such as Third World Network, South Centre, medico international, the World Council of Churches and Health Action International, participating in the preparation of a first WHO watch during the Executive Board meeting of WHO in January 2011.

Before and during the WHO Executive Board meeting, the reform of the World Health Organization has become a major issue. It now looks as if the WHO Director General, after having submitted to the EB a report on "The Future of Financing for WHO", gives highest

priority to this issue. But this is a new story, in 2011 already – and we will report about it and about the related activities of our Network next year.

"The MMI Network will focus joint advocacy on the World Health Organization. The Network is in official relations with the WHO. We will continue to participate and intervene in the World Health Assembly and other global and regional WHO (and WHO lead) structures, programs, events and consultations. We will establish coalitions and joint programs with other civil society organisations or networks pursuing the same tasks. At the same time, we will contribute to monitor the development of the World Health Organization and to strengthen the WHO as the international coordinating body for issues related to people's health."
*MMI Network Strategy 2011-15*

**Sharing resources and promoting positions**

***Monthly e-mail newsletter published by the MMI secretariat:*** Since its start in January 2008, the monthly MMI e-mail newsletter includes, in addition to the Network members' resources and news and the collection of resources on "MMI topics" such as contracting, human resources or research partnerships, a selection of "global health policy" news, with the intention to make global issues and debates better known to the Network members, eventually laying the ground for the development of joint advocacy positions and programs. The editorials of the newsletter covered topics such as the impact of the financial crisis on health (January 2009), the ambitions and ambivalent "World Health Summit" in Berlin (November 2009), the swine flu pandemic (February 2010), the future of the People's Health Movement (March 2010), and the role of NGOs in health systems strengthening (October 2010). Realizing the potential of the editorial, we then successfully called Network members to contribute "political" editorials to the newsletter.

***MMI updates:*** In June 2009, the MMI secretariat started to publish "MMI updates" on Twitter: "News on international health policy, practice and cooperation." Since then more than 900 tweets have been published (about 50 news/month) and read by about 145 "followers" (subscribers using twitter) and by an unknown number of RSS subscribers.

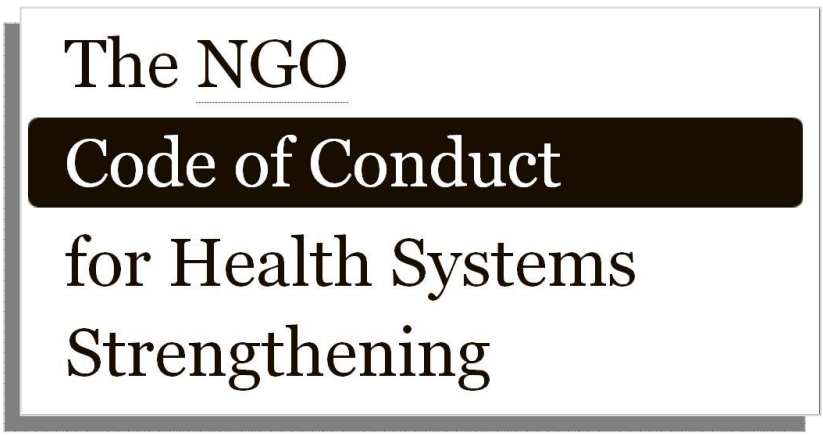
***MMI ePlatform:*** A simple topic guide on "Civil society and global health policy and governance", created in 2008 and regularly updated by the secretariat, gives a quick overview on actors, issues, debates and initiatives related to global health governance.

**Reflecting the role of NGOs in health systems and governance**

Having adopted, in May 2010, a strategy focusing on health systems strengthening, and preparing our related workshop in Amsterdam, in November 2010, the MMI Network re-discovered the *NGO Code of Conduct for Health Systems Strengthening* as a most relevant document for our work.

"The NGO Code of Conduct for Health Systems Strengthening is a response to the growth in the number of international non-governmental organizations associated with increase in aid flows to the health sector. The code was drafted in 2007/2008 by a coalition of activist or service delivery organizations. The purpose of the code is to offer guidance on how international NGOs can work in host countries in a way that respects and supports the primacy of the government's responsibility for organizing health system delivery."
*http://ngocodeofconduct.org*

We were confirmed by Health Alliance International, the host organization for the NGO code, that the code is still much alive. Health Alliance International and other signatories are actively implementing the Code and welcome additional signatories and further dialogue on best practices. Finally, in December, the Medicus Mundi International Network signed on to the code.




As the MMI Network distinguishes itself from an 'umbrella organization' in the sense of "not imposing leadership, coordination or representation on its members" (Network policy), having signed on to the code as a Network does not have direct consequences for the 15 Network members. Nevertheless, we will have to reflect on how to contribute ourselves to its further development and implementation and how to promote it within the Network, its members and partners. Promoting the NGO Code of Conduct for Health Systems Strengthening will also be closely related to our promotion of the WHO Code of Practice on International Recruitment of Health Personnel strongly advocated by our Network.

**Members of the MMI GHG team:** Remco van de Pas, Wemos; José Utrera, Cordaid; Thomas Schwarz, Secretariat
**MMI topic page:** www.medicusmundi.org/en/topics/pnfp-sector-and-global-health-initiatives

# THE HAGUE TO AMSTERDAM (WITH STOP-OVER IN GENEVA)

Based on the experience with its work plan 2009, the Board of the Medicus Mundi International Network, supported by the secretariat, developed again a detailed plan for its own activities in 2010, including the following elements:

- Determination of the MMI Network Strategy 2015
- Renewal of the secretariat agreement with Medicus Mundi Switzerland
- Network promotion, attracting and integrating new members
- Constitution of new Board (2010-2013)
- Follow-up research policy

The Board implemented this plan successfully, swifting its focus from the development of new basic documents for the further development of the Medicus Mundi International Network (Network Policy, Network Strategy) to the implementation of the new strategy.

**Board meeting, 26 February 2010 at Cordaid, The Hague**: The meeting took place in Cordaid's "Memisa meeting room", referring therefore to a piece of MMI history: In 1984 Memisa merged with Medicus Mundi Netherlands to become Memisa Medicus Mundi – later on, in 2000, merging into Cordaid. The Board meeting focused on planning (working groups, Board and secretariat), on network promotion and on the development of the Network Strategy.

**Assembly and Board meeting, 20 May 2010 at Château de Bossey, Geneva**: The Assembly adopted a Network Strategy for the next five years. The presentation of the annual report, the election of the Board and of Nick Lorenz as new Chairperson and the admission of two new members (Wemos and Smile Train Italia) were other highlights of the meeting. After the Assembly there was just half an hour left for the Board meeting. Therefore that meeting was reduced to the essentials.…

**Network meeting, 5 November 2010 at Wemos, Amsterdam:** The meeting hosted by the new Network member Wemos was a launch event for the implementation of our Network Strategy 2011-2015. After a workshop on health systems strengthening, an extraordinary Assembly resulted in the admission of two new Network members (ACHAP and EPN) and the adoption of a new secretariat agreement with Medicus Mundi Switzerland. Finally, in a short meeting, the Board discussed its modalities of work.

**MMI Board (2010-13)**

from left to right:

- Carlos Mediano, MM Spain, vice-chairman
- Nick Lorenz, MM Switzerland, chairman
- Guus Eskens, vice-chairman
- Nina Urwanzoff, Misereor, secretary
- Giovanni Putoto, Cuamm, member
- Bernd Pastors, action medeor, treasurer
- Christina de Vries, Cordaid, representing Board member Monique Lagro

**Four new Network members**

The Dutch **Wemos Foundation** envisages a world in which every person can realize his or her right to the highest attainable standard of health. Millions of people in developing countries are trapped in the vicious circle of poverty and ill health. Wemos wants to break this and structurally improve the health situation in developing countries. Wemos distinguishes the following three strategies: Wemos promotes policies that support national health systems contributing to the structural improvement of people's health; Wemos works together with civil society organizations in Bangladesh, Bolivia, Brazil, India, Kenya, Uganda and Zambia; Wemos mobilizes the support of health workers and (medical) students in the Netherlands by organizing campaigns and awareness raising activities.

*www.wemos.nl*

**Smile Train Italia** is a Humanitarian Association that carries out reconstructive and maxillo-facial plastic surgery in developing countries on poor children affected by serious facial malformations, burns and war injuries. Smile Train Italia works in the field of international health cooperation in order to help and to promote health care and scientific development in developing countries. In particular, Smile Train Italia is professionally involved in the following areas: Operating children affected by cleft lip and palate giving them a new smile and a new lease on life; the organization of theoretical and practical training programs in plastic and maxillo-facial surgery and anaesthesia practices; the carrying out of scientific projects and protocols, submissions to open-access international journals.

*www.smiletrain.it*

**Ecumenical Pharmaceutical Network** (EPN) is a Christian, not for profit, independent organization committed to the provision of quality pharmaceutical services as a means to achieving global goals and targets on health and access to medicines. EPN is a worldwide network of associations, institutions, and individuals who have an interest or are involved in the delivery of just and compassionate quality pharmaceutical services. EPN's strategy seeks to strengthen the Church pharmaceutical sector and enhance interventions that improve people's access to quality pharmaceutical services, informed by EPN's experience of supporting church pharmaceutical systems for over two decades.

*www.epnetwork.org*

**Africa Christian Health Associations Platform (ACHAP)** is a networking forum for Christian Health Associations and Networks from Sub-Saharan Africa. The forum has been established through the inspiration and support of World Council of Churches. The core functions of the forum are coordinated by a Secretariat Office hosted by the Christian Health Association of Kenya (CHAK) in Nairobi. The forum's core mandate is to facilitate networking and communication among Christian Health Associations (CHAs) and to create a stronger voice in advocacy. Various Christian Health Associations in Africa have a form of Christian Health Association or a Faith Based Group.

*www.africachap.org*

# VICTORIANO PÉREZ'S TWO STORIES

**A story from Guatemala, told by Medicus Mundi Navarra, a member of the Federation Medicus Mundi Spain (FAMME). The story is told twice: how it could have happened, and how it really was. The story illustrates what inclusive primary health care really means and that it can be an important contribution to strenghtening a national health system.**

Victoriano lives in Las Barrancas, a very remote, rural, indigenous community in Guatemala. He is suffering from a sharp pain in the chest for some days. The pain comes and goes, but it is worse when he is tired from work. He cannot sleep at night. He has nightmares. He has heard his elders talk of the "susto" (fright). He cannot bear it anymore and decides to go to a healthcare centre in the area. This is not an easy task to do. He must travel for three hours along tracks that are in a poor state. Victoriano does not have a car. He must spend part of the savings from selling his crops on paying someone else to take him there. The journey seems never-ending. Many thoughts pass through his mind: memories from his childhood, being cared for his mother and the fear of not finding a cure or not being able to continue supporting his loved ones. At last he arrives at the town where the Ministry of Health has one of its modest health centres. Victoriano feels weird sitting there amongst some women and children in a waiting room that is alien to him. A nurse calls his name and ushers him into the nurse office. He tries to explain to this person in a white coat what has been happening to him while she takes notes on a piece of paper. He struggles expressing himself in Spanish. The nurse does not speak "mam", his mother tongue. It is one of the 25 languages spoken in Guatemala. How will she understand that I have the "susto"? He says, thinking out loud. The nurse makes fun of him. She tells him that the "susto" does not exist and that he should take the medicine she is prescribing him.

After a ten minute consultation Victoriano leaves with a piece of paper saying that he must buy some pills with a very complicated name. He have to look for a pharmacy. In Guatemala there are many, but they are very expensive. On the way home a street market vendor offers him medicines. Victoriano rummages in his pocket. He must keep some money for his return journey. He therefore decides to only buy two pills, instead of the 20 that he has been prescribed for the entire course of treatment. The name of the pills does not mean much to him, but their appearance does. They are red. "Red?" he asks himself. "This cannot be good. Sometimes I feel a burning sensation in the pit of the stomach. This is a hot illness," he says to himself. Four hours later he arrives at his small house, gets into the bed, and the nightmares and pain continue. The "susto" does not pass off. "Tomorrow I will go and visit the Mayan healer", he thinks as he tries to fall asleep.

Victoriano and his wife Cia

**An inclusive healthcare model: a truly intercultural and comprehensive approach**

This is the story of what could have happened to Victoriano or many other people who belong to rural communities in Guatemala where 41% of the population are of indigenous descent. But fortunately it was not the case. Victoriano had the good fortune to live in one of the three districts where Medicus Mundi has been developing ***Inclusive Primary Healthcare Model*** pilot schemes for the last 12 years. The Ministry has recently decided to sponsor and consolidate the model which will surely be inspiring for an EU-funded proposal for piloting this comprehensive and inclusive healthcare approach – which is focused on the human right to health and the intercultural and gender equality – in Guatemala, Bolivia and Peru. This initiative aims to be one day the basis for a valid model for the whole of Latin America.

Victoriano Pérez's true story is not the one told above. It really is quite the opposite. The so-called Inclusive Primary Healthcare Model is based on the idea that traditional medicine (very deeply-rooted and developed in Mayan culture) and Western medicine (academic biomedicine) do not detract from or are opposed to each other. On the contrary, they complement one another from the triple individual, family and community points of view, adding to this as well the human rights and gender equality based approach. Victoriano's reaction was to try first self-care (by asking his elders and looking for advice in the community), and then go to a pharmacy or visit a "curandero" (medicine man). Only after this did he think of going to the doctor. However when Victoriano felt ill there was no need to travel anywhere to find healthcare. A few metres from his home there was a Community Healthcare Centre, one of the key initiatives of the Inclusive Primary Healthcare Model. There he was greeted by a community auxiliary nurse which is the first level of primary health care in this model. The auxiliary nurse is part of a community team consisting of two or three people who understand the culture and language of the community and who have been accredited by the Health Ministry as well. They represent the first contact with the people and are supported by another team made up of a professional nurse, a physician and family and community program facilitators who can make referrals and possible transfers to higher levels or institutions depending on the healthcare problem they are dealing with.

Victoriano knows this team of people already, because they are integrated in the community daily life. As a result he could calmly explain them about what he was suffering from. He could feel he was being listened to, and properly understood. This auxiliary nurse had previously seen many cases of people who complained of the "susto" like Victoriano before. She can also recognise the symptoms of "empacho" (a gastrointestinal condition), "ojeado" (evil eye) and even "hechizo" (a curse). Some of these illnesses do not always have an equivalent in biomedical terminology, but according to Mayan culture they are related to the harmony in the person's

energy. Considering as well the knowledge about this health approach is very helpful for the detection of chronic problems or serious illnesses.

The auxiliary nurse also knows that, for Victoriano, what the "curandero" (medicine man) says is as important as the medical examination at the health centre. This will also help the auxiliary nurse to confirm her initial diagnosis. That is the reason why she has no issue with sending him to visit a Mayan healer with great credibility in the community as well. Their work will be complementary. When the Inclusive Healthcare Model was being developed these "curanderos" or healers were contacted and they expressed their willingness to work in a "coordinated, although not integrated" manner. This is enough for combining efforts and providing a health treatment in which both traditional medicine and biomedicine complement each other. The Mayan healer's main tools are medicinal herbs and energy. The Western biomedicine contributes with all their technical means and chemical findings... Victoriano will then return to the public health care personnel that will benefit from this double diagnosis by means of different data information systems, standards, conventions and procedure guidelines. The health treatment becomes an open path based on trust and interculturality.

However, as important as the remedy is the prevention. For this reason, the Community Health Centres have also become a place where the community members receive and share information about diseases and approve measures related to all aspects of health which extend further than the own individual sphere. People will never be healthy if they are lacking of water supply, balanced diets and a proper management of the resources. All these components are present in a model – which relies on the willingness of the public authorities to support their implementation – aiming to offer a solution for the healthcare problems suffered by thousands – or millions – of people living in the rural areas of a diverse and multicultural continent.

- To read more: Juan Carlos Verdugo Urrejola et al.: Del dicho al hecho. Los avances de un primer nivel de salud incluyente, http://www.medicusmundi.es/navarra/publicaciones/libros
  Photos: (c) Medicus Mundi Navarra

# A YEAR OF UNEXPECTED SMILES

**In 2010, thanks to the organization of successful surgical missions and scientifical workshops, Smile Train Italy developed a great position on international cooperation focused on health-care and quality of life. Smile Train Italy's working group had a good year, carrying out of nine surgical missions, operating 537 babies with cleft lip and palate and other facial deformities, with the entrance of the organization in the activity of social network, and the realization of training courses based health-care and clinical research addressed for many physicians and nurses.**

Smile Train Italy works with great autonomy and plays a crucial role in health provision for babies with cleft lip and palate in many developing countries.

The influence of the global financial crisis is spreading out to almost all areas in society significantly, affecting also health-care industry and medical job market. Furthermore, in this scenario, thanks to the support of volunteers, friends and partners Smile Train Italy has managed to complete the planned missions, projects and activities reaching the following results: carrying out of nine surgical missions operating 537 babies; continuation of existing projects based on health-care and clinical research; planning of many fund-raising activities; creation of professional collaborations and relationships (by means of social network collaboration tools for example Facebook, but also through the MMI Network).

The volunteers of Smile Train Italy have given their valuable support to the following under-developed countries: Indonesia (Tarakan – Tarakan Public Hospital), the Democratic Republic of Congo (Kinshasa – Cliniques Universitaire de Kinshasa), Haiti (Port-au-Prince), Bangladesh (Gaibandha – The Emirates Friendship Hospital Ship), Tanzania (Dar Es Salaam – Mbweni Hospital), Ethiopia (Addis Ababa) and Iraq (Nasiriyah – Military Base Camp Mittica).

In addition, at the end of October 2010 an assessment mission has been conducted in Benin in order to verify the possibility of carrying out a mission of plastic and reconstructive surgery in 2011. In 2010 the surgical missions have been completed successfully thanks to the professionalism of the following health-care specialists: plastic and maxillo-facial surgeon, paediatric surgeon, anaesthesiologist, paediatrician, nurse and a mission coordinator. Moreover, the association has renewed its support on behalf of all those little and young patients with serious deformities and therefore can not be operated on the spot. So in 2010, Smile Train Italy has planned the trip and stay in Italy for nine babies (accompanied by their parent) in order to undergo plastic surgery in the Italian hospitals with which the organization teams up for years.

Regarding the fund-raising activity, Smile Train Italy has organized many events such as theatrical performance, fund-raising dinner, sms campaign, auction of wine, setting up of stands in many exhibitions and photographic exhibition with the main goal to give back smiles and to donate the hope of a new life to many babies.

Smile Train Italy developed also some activities and projects in the field of scientific research; proposals and/or scientific projects are based on Health Systems Strengthening (HSS) in developing countries improving access to primary health-care and maternal and infant health.

Smile Train Italy with the technical support of the Italian Society of Gynaecology and Obstetrics (SIGO) planning to develop a scientific research for the protection of maternal and child health by means for the supplementation of folic acid for Congolese pregnant women. This protocol study aims primarily to perform a possible research in the field of prevention and care for congenital disorders. The study is progressing also thanks with the support of the Medicus Mundi International Network and its members who have expressed interest in the research.

At the end of 2010 and the beginning of 2011, Smile Train Italy has organized a technical-medical workshop focused on the treatment of cleft lip and burns. The meeting was organized with the cooperation of the hospital "Arcispedale S. Anna", Department of Paediatric Surgery, and with the precious support of the Italian Red Cross of the city of Ferrara. In this workshop

Smile Train Italy presented a report about humanitarian missions and the projects conducted in 2010 and also showed a number of future initiatives, activities and implications for further health workforce strategy. During the meeting the President and the collaborators of Smile Train Italy had the great pleasure of getting to know Dr. Fabian Schumacher, a representative of Medicus Mundi Italy, who attended the conference as a speaker, presenting the activity of the Medicus Mundi International Network. Moreover, in this workshop Smile Train Italy developed a training course addressed to the maxillo-facial surgeons and specialists, performing live reconstructive and plastic surgeries (by means of the operational support of video conferencing). The workshop was a success and it proved to be an exceptional scientific, cultural and social experience.

We end our short report with the testimony of a volunteer nurse, who participated in the surgical mission in Bangladesh from 22 to 30 April, 2010. This testimony shows the true love and passions of the volunteers of Smile Train Italy for these babies and their families.

*"The mission is ended. I came back home in my hectic and aseptic daily life. I wish I had more time to reflect on 'why and how', on my feelings, reflections and thoughts. Our western country is very different, we are always rushing, always late and we do not have time to reflect and think about our feelings. Upon our arrival in Bangladesh, the initial impact was certainly not the best maybe because we were tired from the journey or excited for the adventure with the seaplane. Instead of flying on the water's surface the plane sped up ... above the clouds. Despite the operating difficulties I confess that it was the most incredible experience of my life and it was the most beautiful mission! My great admiration is certainly addressed to the whole team, our complicity was perfect and I loved the intimacy that is created between us. A great thank is also addressed to local people, to the extraordinary doctors and nurses, they pampered and supported us and they actively participated in the surgery's activity both in the operating room and recovery room. The people were very kind, hospitable with us, proud and dignified. All this love can be glimpsed by the eyes of the mothers and seeing their little babies 'changed' they embraced us at the end of surgeries."*

- Authors: Dr. Fabio Massimo Abenavoli, President, and Dr. Marta Romagnoli, Secretary, Smile Train Italy. Illustrations: © Smile Train Italy

ECUMENICAL PHARMACEUTICAL NETWORK

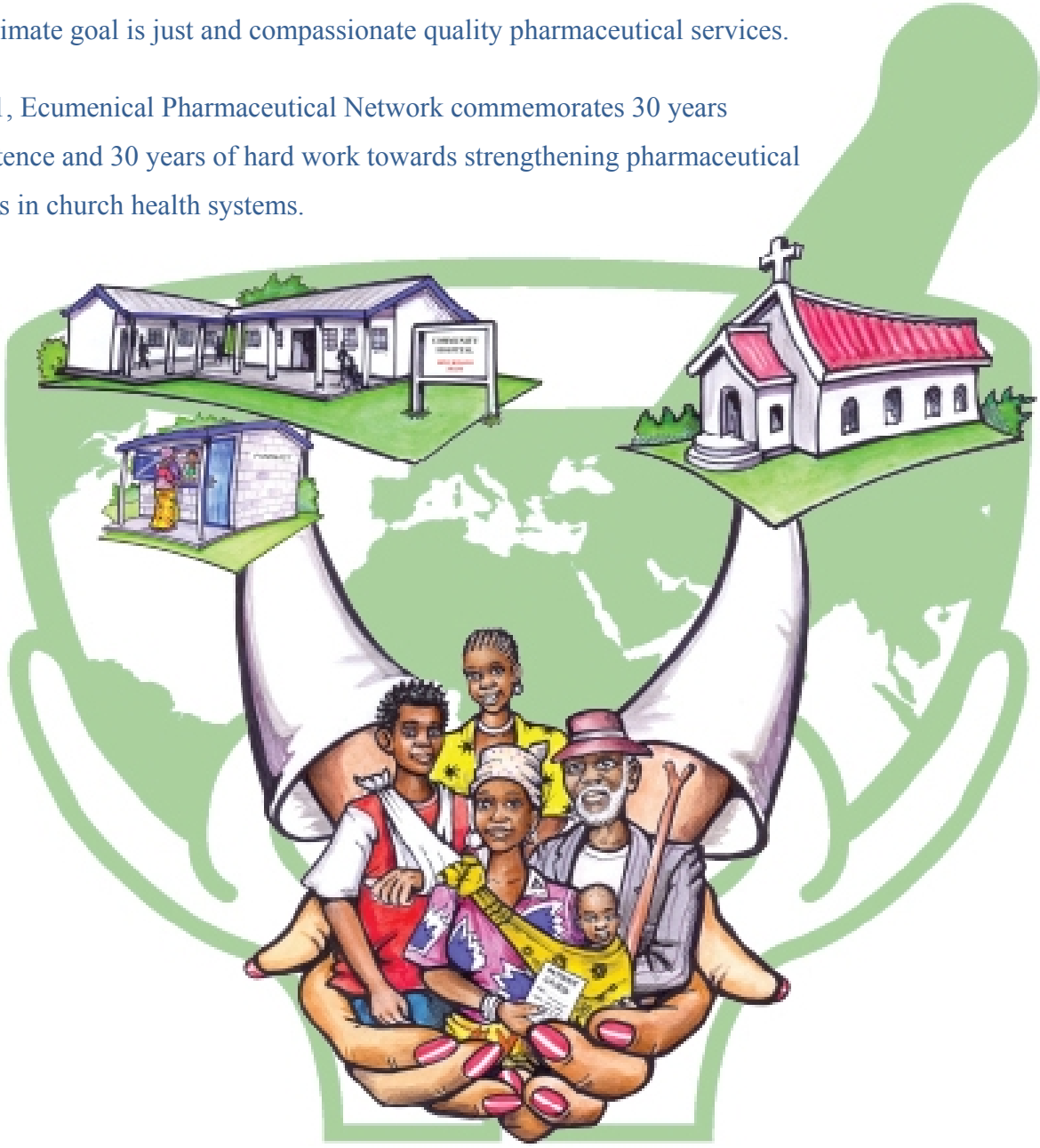
# 30 YEARS OF STRENGTHENING PHARMACEUTICAL SERVICES IN CHURCH HEALTH SYSTEMS

**In 1981 the World Council of Churches started, within its Christian Medical Commission, a programme to address pharmaceutical issues in Church Health Systems. This programme evolved over the years into what is now the Ecumenical Pharmaceutical Network: an independent non-profit Christian membership organization.**

Over the years, our organization, with its many members and partners, has worked with church health systems in various areas such as capacity building of pharmacy professionals, improving quality of medicines, raising the profile of church pharmaceutical agencies, advocacy for increased access to anti-retrovirals and improving access to relevant pharmaceutical information.

Our ultimate goal is just and compassionate quality pharmaceutical services.

In 2011, Ecumenical Pharmaceutical Network commemorates 30 years of existence and 30 years of hard work towards strengthening pharmaceutical services in church health systems.

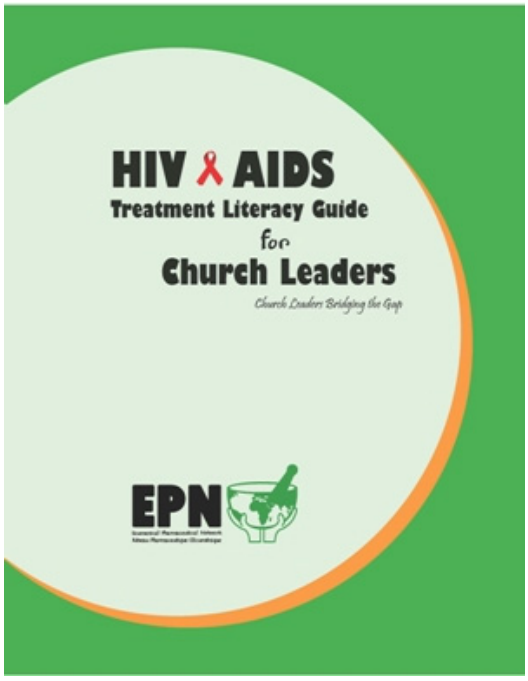


In its strategy 2010–2015, EPN has defined the following four priority areas: Access to Medicines; HIV and AIDS care and treatment; professionalization of pharmaceutical services; and pharmaceutical information sharing. In addressing these priority areas with specific programmes, we seek to promote approaches that address strengthening of the health system as a whole, working specifically with Church-based organizations. It is estimated that up to 40% of health services in a number of African countries are provided by churches. This contribution is critical for the attainment of the Millennium Development Goals (MDGs) on health. We therefore seek to work with these church systems to ensure that their pharmaceutical services are efficient and effective and guarantee availability of affordable quality medicines to all who need them, targeting especially the poor and the under-served.

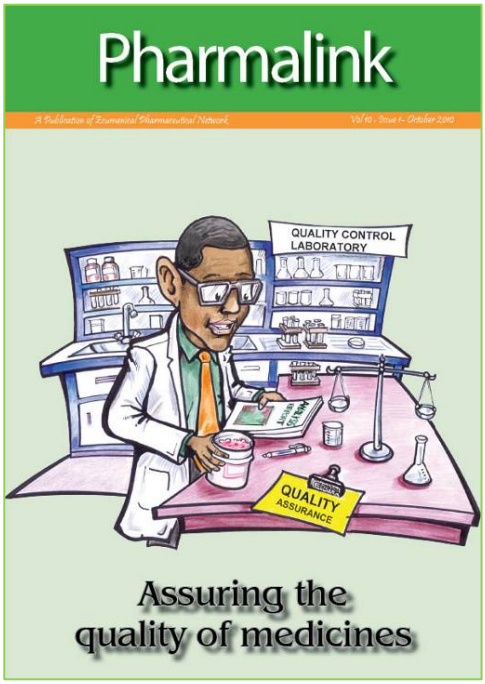
**Priority areas and examples of our work**

- Access to medicines: Wholistic approach towards increasing access that addresses supply systems, medicine use, quality of medicines, pharmaceutical care and affordability.
- International networking and collaboration: More than 75 anglophone and francophone members from over 30 countries across the world.

- Professionalism and good governance: Institutional strengthening through capacity building and distribution of tools to impact governance.
- Training on pharmacy for health facility staff: Provision of guidelines and standards to strengthen pharmacy practice.








- Sharing pharmaceutical information: Electronic and printed bulletins; guidelines for effective and efficient pharmaceutical services support health facility managers, pharmaceutical personnel and all those involved in pharmaceutical service delivery to increase access to medicines and improve quality of patient care.
- Campaign against antimicrobial resistance: Country-based activities on rational use of antibiotics and implementation of hospital-based infection control interventions reached more than 500 health professionals in 2010.
- The HIV and AIDS Treatment Literacy Guide for Church Leaders is a must read for every church leader who wants to address the issue of stigma and discrimination in the church and learn how to care for those infected and affected by the virus. It is available in English and French.
- EPN also offers Treatment Literacy Courses for Church Leaders on invitation from any church or other group. The course can be organized in intensive or modular sessions.

## Moving towards impact

EPN strives to ensure that all the work we do has an impact on our ultimate beneficiaries: children, women and men who are in need of health and those who are entrusted with helping them attain good health. The work being done on reducing hospital acquired infections in the Network is one example:

A series of measures implemented at Mboppi Hospital in Douala, Cameroon in 2010 with support from EPN and funding from ReAct are expected to have a major impact on reducing maternal morbidity and mortality at the hospital. The measures which include implementation of a system to properly dispose of placentas, provision of waste disposal containers, hand washing consumables and equipment and assorted cleaning materials, are expected to significantly reduce the spread of infections in the maternity unit. Infection is one of the major direct causes of maternal morbidity and mortality in the hospital.

## A Network – and a Network member

After applying for membership in June 2010, EPN formally joined the MMI Network in November last year. In a short period of membership, we have already benefited from the frequent contact with the MMI Secretariat and the sharing of information that goes on within the network. We can see how MMI is truly a global platform and we look forward to future opportunities for networking, collaboration and joint advocacy.

- Author: Elisabeth Goffin, info@epnetwork.org
  Illustrations: © EPN

# 2010: FINANCIAL FACTS & FIGURES

## Capital Account

| Assets | Previous Year | | 2010 | |
|---|---|---|---|---|
| I. Long-term fixed assets | | 16'445.00 | | 7'979.00 |
| II. Short-term fixed assets | | 107'226.58 | | 116'685.99 |
| Cash in hand | 92.63 | | 109.26 | |
| Cash in banks | 107'133.95 | | 116'576.73 | |
| **Total Assets** | | **123'671.58** | | **124'664.99** |

| Liabilities | Previous Year | | 2010 | |
|---|---|---|---|---|
| I. Net equity | | 97'451.07 | | 107'679.95 |
| Status 1st January | 92'383.13 | | 97'451.07 | |
| Net profit | 5'067.94 | | 10'228.88 | |
| II. Accruals | | 4'700.00 | | 4'500.00 |
| III. Project funds not yet appropriated | | 9'453.55 | | |
| IV. Other liabilities | | 12'066.96 | | 12'235.04 |
| V. Passive deferral position | | | | 250.00 |
| **Total Liabilities** | | **123'671.58** | | **124'664.99** |

## Statement of revenue and expense

| Revenue | Previous Year | Budget 2010 | Accounts 2010 | Budget 2011 |
|---|---|---|---|---|
| Membership contributions | 77'700.00 | 77'700.00 | 78'700.00 | 80'100.00 |
| Donations and subsidies | | | 1'044.87 | |
| Interest and similar income | 1'570.15 | 2'000.00 | 1'757.40 | 1'000.00 |
| Income for project administration | 2'309.07 | 3'000.00 | 125.67 | 2'000.00 |
| **Subtotal Revenue** | **81'579.22** | **82'700.00** | **81'627.94** | **83'100.00** |

| Expenses | Previous Year | Budget 2010 | Accounts 2010 | Budget 2011 |
|---|---|---|---|---|
| General expenses secretariat | 48'000.00 | 48'000.00 | 48'000.00 | 60'000.00 |
| Travel costs / hospitality | 8'336.73 | 13'000.00 | 5'752.49 | 15'000.00 |
| Other expenses secretariat | 3'535.15 | 5'500.00 | 2'504.77 | 5'500.00 |
| Public relations and printed matter | 447.09 | 4'500.00 | | 2'500.00 |
| Project expenses not covered by project funds | 230.16 | 2'000.00 | 1'170.97 | |
| Other expenses | 7'496.15 | 9'500.00 | 5'504.83 | 6'700.00 |
| Investment and related depreciations | 8'466.00 | 8'466.20 | 8'466.00 | 7'979.00 |
| **Subtotal expenses** | **76'511.28** | **90'966.20** | **71'399.06** | **97'679.00** |
| **Net win / loss** | **5'067.94** | **- 8'266.20** | **10'228.88** | **-14'579.00** |

All figures in EUR

This is a summary of the financial statements of the MMI Network. Details and explications will be given at the Network's General Assembly in May 2011. The "Report on the Audit of the Financial Accounting as of December 31, 2010 for the Association Medicus Mundi International e.V." by Dr. Heilmaier & Partner GmbH is available at the MMI secretariat.

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